Washington State Department of Health

West Nile Virus
Enhanced Surveillance Form

Patient Name:_____ **PHIMS Number:**_____
County: _____ **Investigator:** _____

1. **Before your West Nile virus infection, did a health care provider ever tell you that you had any of the following medical conditions?**

Diabetes	☐ Yes	☐ No	☐ Unknown
High blood pressure (hypertension)	☐ Yes	☐ No	☐ Unknown
Heart attack (myocardial infarction)	☐ Yes	☐ No	☐ Unknown
Angina or coronary artery disease	☐ Yes	☐ No	☐ Unknown
Congestive heart failure (CHF)	☐ Yes	☐ No	☐ Unknown
Stroke	☐ Yes	☐ No	☐ Unknown
Chronic obstructive pulmonary disease (COPD)	☐ Yes	☐ No	☐ Unknown
Chronic liver disease	☐ Yes	☐ No	☐ Unknown
Kidney failure or chronic kidney disease	☐ Yes	☐ No	☐ Unknown
Alcoholism	☐ Yes	☐ No	☐ Unknown
Bone marrow transplant	☐ Yes	☐ No	☐ Unknown
Solid organ transplant	☐ Yes	☐ No	☐ Unknown

If yes: What organ was transplanted? _____
What year was the transplant? _____

Cancer	☐ Yes	☐ No	☐ Unknown

If yes: What type(s)? _____
What year were you diagnosed? _____
Are you currently being treated for cancer? ☐ Yes ☐ No ☐ Unknown

2. **Before your West Nile infection, did a health care provider ever tell you that you had a medical condition that limited your ability to fight an infection?** ☐ Yes ☐ No ☐ Unknown
   If yes: What condition(s)? _____

3. **At the time you were diagnosed with West Nile virus infection, were you taking any of the following types of prescription medications or treatments?**

Chemotherapy	☐ Yes	☐ No	☐ Unknown
Other treatments for cancer	☐ Yes	☐ No	☐ Unknown
Hemodialysis	☐ Yes	☐ No	☐ Unknown
Other treatments for kidney disease	☐ Yes	☐ No	☐ Unknown
Oral or injected steroids (not inhaled or topical)	☐ Yes	☐ No	☐ Unknown
Insulin or other medications to treat diabetes	☐ Yes	☐ No	☐ Unknown
Medications to treat high blood pressure	☐ Yes	☐ No	☐ Unknown
Medications to treat coronary artery disease	☐ Yes	☐ No	☐ Unknown
Medications to treat congestive heart failure	☐ Yes	☐ No	☐ Unknown
Medications that suppress the immune system	☐ Yes	☐ No	☐ Unknown

4. **Which of the following sources provided the information above? (check all that apply)**

Patient	☐ Yes	☐ No	Family member/friend	☐ Yes	☐ No
Provider	☐ Yes	☐ No	Medical record	☐ Yes	☐ No

When complete, please fax this form to CDES at (206) 418-5515
Note: **The information on this enhanced surveillance form is not included in PHIMS**